

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/14/2020
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 550 SS=D	<p>A COVID-19 Focused Infection Control Survey was conducted by the State Agency on September 14, 2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Other deficiencies were cited. Total census 44.</p> <p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her</p>	F 550	<p>1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>a. Administrator educated LPN #1 on Assistance with Meals Policy</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>a. All residents have the potential to be affected by alleged deficient practice therefore; observational rounds were completed 9/21 with no concerns noted</p>	<p>9/15/20</p> <p>9/21/20</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/15/2020  
FORM APPROVED  
OMB NO. 0938-0391

FORM CMS-2567(02-09) Previous Versions Obsolete

Event ID: QMHH11

Facility ID: TN1815

If continuation sheet Page 2 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/14/2020
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 550	<p>Continued From page 2</p> <p>Review of the Quarterly Minimum Data Set (MDS), dated 7/16/2020, showed Resident #1 had a Brief Interview Memory Score of 13, indicating the resident was cognitively intact. Continued review showed Resident #1 required supervision with eating with a 1 person physical assist.</p> <p>Observation of Resident #1 on 9/14/2020 at 12:36 PM showed LPN #1 stood to assist Resident #1 with her meal.</p> <p>During an interview on 9/14/2020 at 5:08 PM, LPN #1 confirmed she was standing while assisting Resident #1 with the noon meal.</p> <p>During an interview on 9/14/2020 at 7:30 PM, the Administrator confirmed LPN #1 was to sit while assisting residents with their meals.</p>	F 550			